Walter Reed Cardiovascular Center

A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

Commentary
Marina Vernalis, DO FACC

Thought we forgot to send you a Newsletter? Never!

Our Newsletter will now be distributed mid-month in order to provide the call schedule for the upcoming month in advance.

Due to additional deployments we will be temporarily reducing our Outreach Clinics at Ft Meade (Feb-April) and Fairfax (May-June). Any and all patients will be accommodated here. Just call 202-782-3832/3833 and ask to speak with the "E-DOC" or page 202-356-1111 x107-3311.

As always we remain available for e-mail, phone or page consultations for all of our primary care providers throughout the NCA/NARMC. Utilize the provided contact information for patient diagnostic or treatment questions.

Cardiovascular Update
Daniel E. Simpson, MD FACC

*Coronary Artery Calcium Score Combined With Framingham Score for Risk Prediction in Asymptomatic Individuals**

Background: The Framingham Risk Score (FRS) is utilized to predict the 10-year risk of a cardiovascular event in patients without known disease. It is believed that additional testing such as EBCT may enhance this. Better risk prediction may help modify the intensity of risk factor modification.

Methods: Prospective observational population study of 1461asymptomatic participants over the age of 45 with at least 1 coronary risk factor. They were screened between 1990 and 1992 and contacted annually to assess for coronary heart disease.

Results: With a median of 7 years of follow-up, 84 patients had MI or CHD death. An additional 70 patients died of any cause. A calcium score > 300 improved risk prediction for patients with a FRS > 10% ($P < 0.001$)

Conclusion: A high coronary artery calcium score (> 300) can modify the predicted risk of non-low risk FRS.

Comments: Of note, low calcium scores did not reduce the predicted risk of the Framingham score. A high calcium score with an intermediate Framingham score (10-20%, 10-year risk) may indicate that more aggressive risk factor modification therapy is required – i.e, diet, weight management, BP control, exercise, aspirin and statins for lipid control. Patients with a high-risk Framingham score (>20%, 10-year risk) should have maximal risk factor management regardless of calcium score.

FRS Calculation:
www.cardiology.palo-alto.med.va.gov/tools/medcalc/fram/

*JAMA. 2004;291:210-215 www.jama.com

Guideline Review*
Stephen Welka, DO FACC FASE

*Recommendations for Patients With Asymptomatic Left Ventricular Systolic Dysfunction (Stage B)**

Class I
- ACE inhibition in patients with a recent or remote history of MI regardless of ejection fraction
- ACE inhibition in patients with a reduced ejection fraction, whether or not they have experienced a myocardial infarction
- Beta-blockade in patients with a recent MI regardless of ejection fraction
- Beta-blockade in patients with a reduced ejection fraction, whether or not they have experienced a myocardial infarction
- Valve replacement or repair for patients with hemodynamically significant valvular stenosis or regurgitation
- Regular evaluation for signs and symptoms of heart failure

Class IIb
- Long-term treatment with systemic vasodilators in patients with severe aortic regurgitation

Class III
- Treatment with digoxin in patients with left ventricular dysfunction who are in sinus rhythm
- Reduction of dietary salt beyond that which is prudent for healthy individuals without hypertension or fluid retention
- Exercise to prevent the development of heart failure
- Routine use of nutritional supplements to treat structural heart

disease or prevent the development of symptoms of heart failure

Class I – General agreement that procedure/treatment is useful & effective
Class II – Conflicting evidence and/or divergence of opinion
Class III – Not useful/effective and in some cases may be harmful

*ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult (2001)

www.acc.org/clinical/statements.htm

Cardiovascular Trials at WRAMC

CARDIASTAR
PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiology

Questions/Referrals: Please contact Daniel Simpson

OPTIMIZE-HF
Assessment of inpatients with CHF and/or LV dysfunction to determine if guideline treatment is appropriately implemented

Questions/Referrals: Please contact Stephen Welka

WARCEF
Randomized, double-blind comparison of coumadin versus aspirin for the reduction of death and stroke in heart failure patients (EF < 30% and in sinus rhythm)

Questions/Referrals: Please contact Stephen Welka

RESCUE
Randomized, open label comparison of unfractionated heparin versus low molecular weight heparin in the treatment of high-risk non-ST elevation acute coronary syndromes

Questions/Referrals: Please contact Daniel Simpson